DASIS STATE DATA ADVISORY GROUP MEETING

October 26–27, 2004
Dallas, Texas

SUMMARY of DASIS STATE DATA ADVISORY GROUP MEETING

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This was the 18th regional meeting to be held with State DASIS representatives. It included representatives from Alaska, Arizona, Colorado, Kansas, New Mexico, Oklahoma, Utah, and Texas, along with staff from the SAMHSA Office of Applied Studies (OAS), the Center for Substance Abuse Treatment (CSAT), Mathematica Policy Research (MPR), and Synectics for Management Decisions, Inc. (Synectics), and a representative from Westat.

The DASIS regional meetings are held to provide an opportunity for face-to-face discussions among State DASIS representatives, staff of OAS, and the DASIS contractors, Synectics and MPR. The meeting agenda, while planned beforehand to include items of mutual interest, is flexible to maximize the opportunity for discussing issues of particular importance to the State representatives in attendance. Through discussion and brief presentations, States are informed about recent OAS activities and are given an opportunity to share with OAS and each other their concerns and solutions to common problems in data collection and management of information.

Opening
Charlene Lewis, acting Director of the Office of Applied Studies (OAS), gave opening remarks. She emphasized the importance of these meetings to OAS and the value SAMHSA receives from the State presentations and the interchange of ideas during the meeting with the State representatives. Charlene reminded the group that comments and suggestions at these meetings often result in substantive changes in the DASIS programs. For example, when she was responsible for the data archive, comments received during the regional meeting were very helpful in the archive redesign.

National Survey of Substance Abuse Treatment Services (N-SSATS)
Geri Mooney and Barbara Rogers, MPR, reported on the 2004 N-SSATS.

The overall response as of October 4 was a remarkable 96.8 percent for State-approved facilities. Nine States had 100 percent. Among the States attending the meeting, the response rates ranged from 92.7 percent to 98.7 percent.

Until 2002, 70 to 75 percent of the questionnaire responses were received by mail, with the rest completed by telephone. In 2002, the questionnaire was made available on the Web. Ninety-three percent of the people who log on the Internet go on to complete the survey on the Web.

For 2004, of the facilities sent questionnaires, 8.5 percent were closed or no longer provide substance abuse treatment. Of the eligible facilities, slightly under 50 percent completed the questionnaire by mail, and just under 30 percent responded on the Web. After two mail questionnaires were sent to facilities, survey non-respondents were called and asked to complete the survey on the telephone. In 2004, this accounted for 20 percent of the responses.

Among the attending States, there was some variability, but the highest rate of Web completions was Utah's 41 percent.

Obviously, having Internet access is key to using the Web version of the questionnaire. Overall, 91 percent of the facilities reported having Internet access. Since 2002 this percent has increased 7 percent. Six of the eight attending States had over 90 percent Internet access, including New Mexico at 100 percent.

It is interesting to compare the mode of completion in 2003 (mail, Web, or telephone) to the 2004 N-SSATS facilities that completed the questionnaire using the Web. Of those facilities completing by Web in 2004, 54.4 percent also completed by Web in 2003, 30.9 percent completed by mail, and 14.7 percent completed by phone. Conversely, 59 percent of the 2003 Web respondents responded by Web again in 2004. The appeal of the Web appears to be growing.

Accuracy of reporting, measured by whether facilities indicate they reported actual counts as opposed to estimates, varies by mode and service. In 2004, the mail mode has the highest percentage of actual reports, followed by the Web and phone modes. The highest percentage of actual counts is 81.5 percent, made by mail respondents reporting residential clients. This is closely followed by the 78.7 percent of actual counts made by Web respondents reporting residential clients. These relationships by mode appear in all three services, with outpatient facilities reporting the lowest levels of actual client counts. In 2003, the relationship between mail and Web modes was the reverse, with Web respondents reporting the higher percentage of actual client counts.

In 2003, the Office of National Drug Control Policy (ONDCP) asked SAMHSA to include a question on outpatient capacity. The 2003 N-SSATS asked respondents, "Considering the available staff resources, how many additional clients could have been enrolled in outpatient substance abuse treatment at this facility on March 31, 2003?" For the 2004 N-SSATS, the question was changed to read, "Without adding to the staff or space available in March 2004, what is the maximum number of clients that could have been enrolled in outpatient substance abuse treatment on March 31, 2004?" Total capacity increased 1.9 percent, but there is a lot of variation across individual States. When MPR asked the State representatives if their numbers seemed reasonable, there was a mixed reaction among the States: some could not comment on the accuracy, and some thought the numbers were reasonable.

Inventory of Substance Abuse Treatment Services (I-SATS)

Alicia McCoy, Synectics, reported on the I-SATS and the importance of States keeping the I-SATS current.

I-SATS began as a database that contained State-approved treatment, prevention, and other non-treatment facilities, but it has evolved to contain five categories of facilities:

1. State-approved facilities
2. Non-State-approved facilities that the State designates as appropriate for inclusion in the National Directory and Facility Locator
3. Opioid Treatment Programs (OTPs) that are certified by CSAT

4. Non-State-approved facilities
5. Federally-owned or -operated facilities

Synectics receives information about new facilities and updates for facilities on the I-SATS through a number of different sources, although the primary sources of information for the I-SATS are the State substance abuse agencies. Most States provide information about new facilities and facility updates on a regular basis through the I-SATS On-Line. Over the past several years, other important sources of facility information have emerged. With the growth and recognition of the Facility Locator, many facilities wish to be included and contact Synectics directly through e-mail and telephone. In addition, periodically Synectics performs an "augmentation" to identify and add new facilities to the I-SATS. This process generally is done by searching the directories of businesses and the American Hospital Association for treatment facilities not on the I-SATS.

Another important source of new or updated facility information is the annual N-SSATS. During these surveys, Synectics receives information about new facilities from other facilities in the survey. Generally, facilities that are part of a "network" report other facilities in the network that did not receive the survey questionnaire. The N-SSATS survey also serves as a means for facilities to update their own information by submitting changes to name, address, and other data on the front cover of the questionnaire.

When Synectics receives a request to be listed in the I-SATS directly from a facility, staff first searches the I-SATS to determine if the facility is currently in the I-SATS. If the facility is not, the facility is added as a non-State-approved facility and the facility information is e-mailed to DASIS State representatives to determine if the facility is State-approved. States usually receive these e-mails from Tara Davis, another member of the Synectics I-SATS staff. When Tara receives a response from a State regarding whether or not the facility is State-approved, she makes a notation in the I-SATS to record that the facility has been reviewed.

Facilities that are added to the I-SATS and approved by the State after the file of facilities has already been "frozen" for the N-SSATS receive a Mini-N-SSATS interview. Mini-N-SSATS interviews are conducted by MPR. If a facility responds, it is added to the on-line Facility Locator during the monthly updates of the Locator. Facilities that have closed or had address changes are also removed or updated during the monthly updating process.

Because facility information is available to and used by the public through the Facility Locator and the National Directory, it is very important that the I-SATS be kept current, complete, and accurate. I-SATS On-Line and I-SATS Quick Retrieval Service (IQRS) are Internet tools that States can use to maintain their I-SATS listings. IQRS allows States to see an up-to-the-minute record of what is currently listed in the I-SATS, including all State-approved, non-State-approved, active, and inactive facilities. When additions or changes are needed, I-SATS On-Line provides an easy method for adding new facilities and changing information for facilities already on I-SATS. When additions and changes are submitted by a State using I-SATS On-Line, the information goes into a staging table for review by the I-SATS staff before the I-SATS database is updated. If there is any discrepancy between the information submitted by the State and information obtained from other sources by Synectics, Tara sends an e-mail to the State to

reconcile this information. Only after any discrepancy is resolved to the satisfaction of the State is the change made to the I-SATS database.

National Provider Identifier
Deborah Trunzo, OAS, discussed the approaching national identifier.

By regulation, all health care providers under HIPAA must apply for a national identifier that must be used with all HIPAA transactions. This identifier will include the facility's name, mailing address, telephone number, and will classify the "facility" as an individual provider, clinic, or facility. Another requirement is that the information be updated every 30 days. The goal is to have a lifelong ID number. This will have an impact on how SAMHSA and the States do business in DASIS, but it is still unclear how the identifier will operate and how it will actually impact on I-SATS and TEDS. It is possible that two separate sets of numbers will have to be maintained, with only the covered entities required to get one, while others can elect to get one. Considering that entities can start filing applications next year it is surprising that more isn't known. As information becomes available, it will be passed on.

SAMHSA Initiatives and Potential Impact on DASIS
Charlene Lewis provided an update on some recent SAMHSA activities, but cautioned that the election results would probably affect upcoming initiatives.

There is no spending bill yet for 2005. SAMHSA is on a continuing resolution until 20 December. At that time it is expected that Congress will wrap all of the spending bills into one. When that is passed, money will be available for programs and grants. Please note that sometimes programs are added or deleted in the process—often there are things in the bills that SAMHSA is not aware of. Some programs may not be funded, while others may be authorized. Meanwhile, the SAMHSA reauthorization is caught up in Congress and is unlikely to be settled before the beginning of the year. If SAMHSA gets reauthorized, the issue of Performance Partnership (Block) Grants (PPG) will be addressed in the new legislation.

Performance measurement is a potent idea, although the PPG process has been long and painful, and the movement around PPG may collapse around the outcome measures. Performance measurement potentially allows you to determine the impact of the money on the services clients are receiving. There is some overlap among the GPRA data, outcome measures, and TEDS. OAS is trying to ensure that most of the TEDS discharge data set is included in the outcome measures. For example, if length of stay is used, and all the research in the literature indicates that the longer the length of stay the better the outcome, it will be very important to record when people enter treatment and when they leave. Other variables can be added, such as: Are they employed at the end of treatment? Are they using drugs before treatment or using drugs after treatment? These things have meaning both programmatically and for measurement. As we move forward, it is going to be important to determine what shape State treatment systems are in. These ideas are very much in a state of formation, so States should think about how PPG will impact on them State and what kind of support they will need.

In response to a question from New Mexico about the lack of consistency between data requests within SAMHSA and the undue burden on the States, Charlene commented that SAMHSA has a

task force working on that problem and that they are making headway. As an alternative course of action, States can monitor the Federal Register notices from the Office of Management and Budget (OMB) about pending surveys and data requests. OMB lists projects and requests comments. These comments are reviewed by OMB and the sponsoring agency.

Status of TEDS Reporting

The 2002 TEDS report was the first since TEDS reporting began in 1990 to include admission data from all the States, D.C., and Puerto Rico. Moreover, as of the first of October, approximately 88 percent of the 2003 admission data had been submitted. Some 2003 data have been received from all but two States.

Currently Synectics uses four reports to monitor the frequency and quality of TEDS reporting.

1) A processing report is generated each time an admission or discharge submission is received from a State. This report shows the number of records processed and any errors found, and it forms the basis of the decision to accept or reject the records.
2) The monthly processing report summarizes the month's activity and is sent to OAS.
3) On a quarterly basis, individual State reports are prepared, each one showing all the records received in the last three years from a particular State. These reports are Synectics' primary method of checking the quality of the data submitted. Each quarter, a report is sent to each State.
4) If the State report shows a significant problem, Synectics sends a problem report to the State requesting clarification and possible correction.

Synectics is now tracking the match rate between admissions and discharges. Staff expects the match rate for discharges submitted to Synectics to approach 100 percent since all clients should, eventually, be discharged in some manner (the only exception being some methadone clients who may remain in treatment indefinitely). Currently, 94 percent of the discharges submitted have a matching admission record. From the reverse perspective, approximately 64 percent of the admission records have a matching discharge. Another general yardstick Synectics uses to evaluate reporting quality is to compare the number of discharges and admissions for a given time period. It expects that within a given year the number of admission records and discharge records should be about the same. Synectics will contact States with large differences to investigate the problem.

Synectics also continues to track admission submissions. If a State falls behind, the chances are good that Synectics' Mayra Walker will call the State representative to find out the reason for the delay.

SAMHSA's goal is to have all the data from a State for one calendar year by the end of the following year. Therefore, the goal this year is to have all the 2003 data in by December 31, 2004. Meeting this time schedule enables the TEDS annual report to be produced in a reasonably timely manner.

Selected Findings from TEDS Data
Leigh Henderson, Synectics, reported on the TEDS discharge data for 2002.

Twenty-five States reported discharge data in 2002. Data from 23 States were used for this analysis. The objective of the study was to examine treatment completion and length of stay (LOS) within service types (outpatient, intensive outpatient, short-term residential, long-term residential, and hospital residential). From each of these services detox and methadone clients were excluded and examined separately.

Shorter-term treatment services had higher completion rates, and there was little difference between treatment completion for different primary substances or by age.

For LOS, the median seems to be a better measure than the average. The average LOS is always longer than the median, indicating a long tail in the distribution. The median is less influenced than the average by extreme LOS due to clients having administrative closures often 60 or 90 days after last contact.

For each type of service, treatment completion rates and LOS were examined for socio-demographic, substance use, prior treatment, and treatment referral source variables. LOS was generally not associated with any of the variables, but treatment completion was associated with some of the variables in different service types.

Median LOS varied from 92 days for outpatient completers (includes both "treatment completed" and "transferred to another substance abuse treatment program or facility") to 4 days for detox. Long-term residential was 71 days, intensive outpatient 52 days, short-term residential 25 days, and methadone 20 days.

Among clients in outpatient treatment, the rate of completion was the highest for White clients (46 percent), next Hispanic clients (38 percent), and then Blacks (33 percent). Completion rates by substance varied from a high of 50 percent for alcohol to 26 percent for opiates.

One of the more significant findings was the relationship between frequency of substance use at admission and completion rates. The rates dropped as frequency of use increased: while almost one-half of clients reporting no use at admission were completers, 27 percent of those reporting daily use were completers.

Examining rates by source of referral, the rates were highest for clients referred by the criminal justice system or employers. Somewhat surprising was the low rate of completion for self/individual referrals (36 percent). As might be expected, the highest completers by employment status were those employed either full- or part-time.

State Presentation: Alaska
The State of Alaska Department of Health and Human Services has recently undergone a reorganization in which the divisions of substance abuse and of mental health were combined. Then, on July 1, 2004, the IT services were integrated and moved away from all of the divisions. These changes have had an impact on the implementation of the WITS system in Alaska: the

project was on hold for sometime, but now we are trying to regroup and move forward. A significant obstacle to a successful implementation was the lack of training for agencies and providers. The original training plan for sending two staff to train providers proved too ambitious. The plan has changed to a "train the trainers" program in which staff from the providers is brought to a central location for training. They in turn go back and train others. Now most agencies have been through a “train the trainers” session.

The department has staff on board that can maintain and make alterations to the basic program. The WITS system with the State wrap around has been deployed to 33 locations throughout Alaska, some in metropolitan areas and some in remote locations. Since this system allows real time reporting over the Web, the biggest concern is how the program will perform in remote locations where the fastest Web access is 56 K data lines. So far the system is running fairly well, although performance remains a concern. (Performance is not an issue for the largest providers because they can report the data in several different types of file formats.) The target date for completion is January 1, 2005. Although this is an ambitious time schedule, the Director is determined to have it finished on time.

The application is a sound one, and while some program changes are still needed, we are on our way to a successful implementation.

State Presentation: Arizona
The Arizona Department of Health Services is responsible for implementing the State’s publicly funded behavioral heath services system. Behavioral Health services include prevention programs for children and adults, services for children and adults with substance abuse and/or general mental health disorders, services for children with a serious emotional disturbance, services for adults with a serious emotional disturbance, and services for adults with a serious mental illness. The system services 125,799 people.

The Department receives funding from the Federal Block Grant, Medicaid, KidsCare, intergovernmental agreements, and State appropriations. In August 2003, the system was revised to include a single enrollment system with a set of HIPAA compliant standardized elements. In the process, the Department eliminated duplicative paperwork and over 50 data elements and instituted a statewide standard client assessment.

In the spring of 2004, a statewide effort, called the Data Reporting and Integrity Improvement Project, was started to improve the timeliness, completeness, and accuracy of the data. The steering committee is co-chaired by the Quality Management Director and the Division Clinical Director. There are four cross-functional subcommittees. One covers claims and encounters, another enrollment and demographic data, the third reports, and the fourth training. Each subcommittee is comprised of members representing clinical, quality management, policy, and IT staff.

Each subcommittee conducts internal reviews of the processes, holds discussions with contractors, makes recommendations for improvements, and develops reports to track progress. Findings to date include a need for an internal forum to talk about consistency in definitions,

manuals, and requirements; further training of provider data entry staff; and standardized reports tracking the timeliness, completeness, and accuracy of the data.

The next steps include developing and implementing provider training, installing system edits, developing standardized management reports for stakeholders and the community, and implementing performance partnership measures.

State Presentation: Colorado

In 2001, it was decided to discontinue the mainframe system. In February 2002, a contractor was hired to build a Web system for substance abuse data collection. The system was ready to handle production in April 2002, and the receipt of batch files began. In Colorado, there are several systems that collect data for large areas of the State. An interface between those systems and the new system had to be built. So there are really two separate systems. In September 2003, clinicians began to report data. Now approximately 280 providers are using the system. We anticipate receiving 100,000 records by the end of the year.

DWI was not submitting some of the specific data required by the system. Staff has been working with the DWI staff to get them in compliance. Once they comply, we will get over 100,000 records a year. It is a real time system using comma-delimited files submitted through a secure system. The data goes through 24-bit encryption. The key to making this Web system successful is making sure all the data coming in and going out are secure.

We collect information at admission and discharge. The system requires a record for both. The system is at a fairly stable point—most of the kinks have been worked out—but there are still some problems.

One continuing problem is the availability of qualified programming staff. There is a pool of programmers that can help but since we are the only system of this type, many of the programmers are not familiar with our system. Therefore we have trouble getting qualified people to work on the system. Another ongoing issue is system security and keeping up with the patches from Microsoft. It requires continual support of competent IT staff to apply these patches properly. As part of our security surveillance, the IT folks were asked to retrieve the backed up data in order to test the backup system. When they did the test, they found they were backing up the wrong server.

Another issue is making adequate bandwidth available for users trying to offload reports from the server. The system uses a Web host to manage traffic. More and more users are using this, which requires more servers, which can be costly. An alternative is leasing space from server farms.

In Colorado, there is a huge increase in methamphetamine use—it surpasses marijuana and cocaine. Our primary drug is alcohol, but methamphetamine use is climbing, and is now up to 16 percent. An examination of use among clients younger than 18 showed methamphetamine is preferred over cocaine 4 to 1, and among Whites under 18 it is preferred 5 to 1.

The representative hopes to do more research on methamphetamine use.

State Presentation: Kansas
The computer system for Kansas Substance Abuse Prevention, Treatment and Recovery Services is a comprehensive one covering client demographic and treatment tracking information, collection of the Addiction Severity Index, and billing and payment information. The data are used for Federal block grant and TEDS data reporting, for State, regional, and provider-level reporting, for tracking billings and payments, and for outcome measures.

Recently data that were housed regionally have been combined into a centralized Web-based system that has improved standardized reporting, eliminates duplicate records, and provides immediate data access for regional users. All data errors can be corrected at the State level.

Kansas recently passed a law requiring four time DUI offenders to serve 90 days in jail and a minimum of one year in treatment. The Department has entered into a memorandum of understanding with the Department of Corrections to treat DUI offenders. The system was revised to accommodate Department of Corrections needs. A unique client identifier has been developed so that client data can be accessed.

Others changes were made to incorporate Medicaid clients and TANF clients. These changes enable the State to audit services and costs of services for Medicaid clients and eliminate fraud through duplicate billing.

Future plans include obtaining data from all providers and maintaining a centralized data warehouse for them, providing information for determining allocation of services statewide, and combining KCPC and ASI into one instrument and updating the KCPC to ASAM II.

State Presentation: New Mexico
In 1995, the substance abuse and mental health divisions were merged and formed a new division called the Behavioral Health Services Division (BHSD). The information system was redesigned to accommodate Y2K, to capture data related to both the mental health and substance abuse client populations, and to support the new Regional Care Coordination Plan (RCCP), which was implemented in 2000. However, since the merger and Y2K, New Mexico's once great job of reporting TEDS has fallen off.

The RCCP system consists of the State contracting with Regional Care Coordinators (RCCs), who are responsible for managing services within their region. The RCCs in turn, directly contract with providers within their region to provide mental health and substance abuse services. The RCCs collect data from the providers and send the data on to the state. The State also contracts with some Native American Providers and Forensic Providers. The contracts with providers are on a fee-for-service basis and the RCCs are reimbursed on a $1/12^{th}$ drawdown. The State also operates substance abuse and mental health (State Hospital) facilities.

The fee-for-service providers were given an Access database developed by the State to collect and submit required data to the State. The RCCs and FFS providers submit four data sets to the State—registration, level of care, scores, and service data. When the State implemented the RCCP, a contractor was hired to develop a system to collect and submit TEDS data using the

data contained in the new Behavioral Health Information System (BHIS). The State hired the contractor to design the new TEDS program to use the level of care data set to track TEDS admission and discharge data. However, before the program was complete, that contractor left, and a new contractor was hired to complete the program. Once the program was completed, the second contractor also left. When the current contractor was hired, problems with the data export process were identified—not all data were being sent each quarter. It was also discovered that the providers and RCCs were opening levels of care, but never closing out the level of care and opening a new level of care as appropriate. Consequently, the TEDS data set suffered. Realizing that the level of care record was not working, the new contractor has been revising the TEDS program to use the service records. The program is almost complete; however, the contract ends November 6th. The State plans to create a new contract so that the contractor can complete the program. Once it is completed, the State plans to send data for the last three or four years.

New Mexico is also in the process of implementing a new behavioral health purchasing collaborative—pulling together approximately 16 State agencies that fund behavioral health services in the State. The main agencies consist of the Department of Health, the Behavioral Health Services Division, the Human Services Department, the Medical Assistance Division (Medicaid), and the Children, Youth and Families Department. Plans are to hire a Statewide Entity to manage all behavioral health for New Mexico.

New Mexico brought up the issue of having trouble getting all the discharge records from the providers and asked for suggestions from other States. Texas indicated that it administratively discharges a client if there is no contact for a certain amount of time. Colorado has tried to reduce the burden on the provider by taking all the information from the admission record: all providers have to do is to update the performance measures. Colorado also has business rules in place to handle disappearing clients: if there is no activity in 90 days, Colorado automatically discharges them. Many other States have similar rules.

State Presentation: Oklahoma

Oklahoma has developed a methodology for tracking treatment episodes and using the information for performance measurement of providers.

In order to match records to create episodes of treatment and then link episodes, it was necessary to create a unique personal identifier. The identifier used is last or maiden name initial, first name initial, sex, and 6-digit date of birth. This ID and the agency identifier are used to link admissions and discharges. Agency episodes are linked to subsequent episodes using a 30-day rule. If there are less than 30 days between transactions, the second transaction is considered part of the original episode; otherwise, the second transaction begins a new episode.

Client-level data are also linked with other agency data. Records are linked with mortality data, arrests data, wage and employment data, DUI convictions, and re-incarcerations.

This information is captured in a report that has total admissions, distribution of admissions across demographic and primary drug categories, number of subsequent admissions, and average number of days between episodes. There were a little more than 12,000 admissions in 2001, involving a little more than 11,000 clients. Some 803 (7 percent) had a second episode. Alcohol

users had the most second episodes, followed by methamphetamine users. The average length of time between episodes was 90.7 days for females and 96.2 days for males.

The division prepares a Management Report for each agency. This report provides descriptive client statistics, count of clients admitted and served by level of care, and reason for discharge by level of care. Another part of the report shows several indicators by level of care for short-term outcomes and long-term outcomes. Each of the indicators is also ranked. State average and the agency score are also provided.

State Presentation: Utah

Approximately two years ago, the substance abuse and mental health agencies merged. Our task is to bring all the data systems under one umbrella into an integrated system. The first step is to find out where we are, followed by creating a plan for where we want to go and setting some goals to achieve the plan.

There are several problems with the current systems that make integration impossible:

- Separate systems require manual manipulation to evaluate;
- Common data items have different formats in the different data sets;
- Manual upload of data;
- Error checks that accept "wrong" data; and
- Data are not available to multiple users.

In developing the new system, we plan to have a unique client and provider identifier. This will allow us to track consumers across programs and time. The system will have the ability to evaluate programs and provide the data in a timely, user-friendly format. We will have a Web-based interactive data reporting system and have a data warehouse environment for data mining.

Before we actually develop the system, we plan to complete our review of the data currently collected and determine all of the Department's requirements. We will also review the systems in Alaska and Texas for their applicability for Utah.

Once these steps are completed, we will begin designing an integrated system that will serve the needs of mental health and substance abuse programs. As careful as we plan to be in the planning and development, we know this will be a difficult task.

State Presentation: Texas

On September 1, 2004, the Texas Commission on Alcohol and Drug Abuse (TCADA), the Department of Health (TDH), and the mental health portion of the Department of Mental Health and Mental Retardation (TDMHMR) merged to form the Department of State Health Services (DSHS). The reorganization aims to provide services in a more integrated and efficient way.

The Mental Health and Substance Abuse Services Division is responsible for managing substance abuse treatment services and continuing operation of the Behavioral Health Integrated Provider System (BHIPS).

BHIPS is a Web-based on-line clinical record developed by the State and is used by funded providers to manage the substance abuse services it provides to clients. The system includes Web-based clinical records, assessment and treatment plans, reporting tools, capacity management, HIV early intervention, prevention outcome monitoring system, and an expenditure accounting system for programs that offer vouchers for supporting services.

The Web-based clinical record includes everything needed to plan, document, manage, and report the treatment of a patient. The record is accessed through the Internet, and records are transmitted via the Internet by providers. The data are protected by special firewalls and other safeguards, thereby assuring the confidentiality of data. Counselors use the system to provide client assessment. The system includes the Addiction Severity Index, DSM IV diagnosis criteria, and other assessment tools. Treatment sessions are documented in the clinical progress notes. BHIPS allows providers and DSHS to share client information on a real time basis. DSHS staff can now conduct desk reviews for specific clients or service levels or for the provider.

Texas operates on a fee-for-service basis, so units billed for services can be documented and verified. Providers cannot submit bills until the services have been documented. Since the BHIPS system has been instituted, there has been an improvement in data quality. Using client identifiers, DSHS can match each client's records at admission, discharge, and follow-up. In addition, by using a probabilistic matching system, clients may be identified when they are admitted to a different clinic and are assigned a different client identification number.

The system provides on- and off-line reports that are available to providers and are useful for program management and self-evaluation. Providers are given a series of charts that show their performance in several key areas in comparison with the State as a whole. Providers are also measured against performance targets. Three measures are used for residential and outpatient services. The measures are completion of treatment, rates of follow up, and abstinence. For detoxification service, the measure is successful detoxification and referral to further substance abuse treatment services.

Program performance can be improved by using the outcome data to identify weaknesses or gaps in services and for feedback to enhance system performance. The data are also used to make resource allocations and in justifying funding requests.

BHIPS can track bed and slot availability throughout the system. This helps providers make referrals when they are full. The system also calculates the number of clients in service by program type, primary substance, demographic variables, and by location—all on a daily basis.

Another part of the system is HIV Early Intervention Case Management (HEI). The program provides information on case management, client referrals, and follow-ups. The system has a narrative section for reporting progress problems and plans. Output from the system provides data for performance measurement. Prevention outcome measures are tracked for youth prevention programs.

BHIP has a voucher payment module, which is being used for two federal grant programs. Vouchers are created to pay for services identified during assessment. The voucher pays for treatment and recovery support services.

Accessing and Analyzing TEDS Data On-line
Charlene Lewis described and demonstrated the system available to the public for on-line analysis of substance abuse data.

The Substance Abuse and Mental Health Data Archive (SAMHDA) was designed to provide researchers, academics, policymakers, service providers, and others with ready access to substance abuse and mental health data. Through the SAMHDA Web site, substance abuse data with complete documentation can be downloaded from the Internet (http://www.icpsr.umich.edu/SAMHDA). Datasets are in SAS and SPSS format, and documentation is in PDF format.

In addition to data downloads, the system provides for direct on-line analysis of the data. The Data Analysis System (DAS) was developed by the University of California at Berkeley, specifically for use on the Internet. Users can compute frequencies, cross-tabulations, means, and correlations using procedures that are user friendly. Subsets of data files can be constructed and downloaded to a local PC. Existing variables can be recoded or recomputed to create customized variables. These variables are saved on-line for 30 days. Customized datasets and codebooks can be downloaded. The documentation includes a title page, codebook notes, weighting information, bibliographic citation(s) and data disclaimer, and descriptions of imputations, data anomalies, and data problems.

State and Sub-State Estimates from the National Survey on Drug Use and Health (NSDUH)
The target sample size for the NSDUH is 67,500 respondents annually. The sample is designed to provide State estimates.

Subject to sample size limitations, direct estimates can be made at the national level for subgroups such as race, pregnant women, and for grouping of ages. Estimates can also be made for States or metropolitan areas, but generally only for large States or metro areas, or by combining several years of data.

For a selected set of outcome measures, State estimates are made using a model-based method. The survey uses a technique called Hierarchical Bayes Estimates. These estimates are a weighted estimate made by combining direct estimates for the State with an estimate for a sub-State-based national regression model.

An evaluation of model-based versus direct estimates found that model-based estimates were more precise than direct estimates but they are limited to certain pre-selected measures. Direct estimates may have a large sampling error but can be done for any variable and subgroup that has a sufficient sample size. Sufficient sample size usually requires combining more than one year of data.

OAS, working with CSAT and the States, is trying to determine sub-State regions that are meaningful to the States. Once these are established, OAS will produce model-based estimates comparable to the ones produced for the States. They will be based on three years of data, from 1999, 2000, and 2001. Because of design changes in 2002, 2002 data cannot be combined with 2001 and earlier data.

Based on feedback from the States on this initial effort, OAS will revise the sub-State areas if needed and produce a second set of estimates based on 2002 through 2004 data. The sub-State areas require a minimum sample of 275. Preliminary sub-State areas were shown for the States attending the meeting.

Web Infrastructure for Treatment Services (WITS)

The WITS system is an Internet-based data recording and reporting system based on similar ones developed in Texas and Maryland. The system allows a State to host and providers to access it over the Internet. The system is designed to be integrated into the provider's business practices, which lowers reporting burden. The system relies on State collaboration and is supported by CSAT. It is primarily set up for substance abuse, but can incorporate mental health services.

WITS has two main functions, agency management and client management. Agency management includes organization, facility and staff management, billing, and administrative reports. Client management includes client profile, intake, screening, assessment, admission, treatment plan, treatment review, discharge, status review, referral, wait list, client notes, and clinical reports.

The expectation is that a State will host the system, either directly or through a contractor. Providers who receive State funds can then be given access at no charge. In preparation of a move to WITS, a State must address a range of policy and business decisions.

WITS' success will rest on ongoing State collaboration. Each State will be given the source code for its own use. It is hoped that any new developments by a State would be shared with other States using WITS. So far, Alaska, Maryland, and Illinois have done this.

States installing WITS are encouraged to set up providers in a manner consistent with N-SSATS reporting, and TEDS standard data items are part of the WITS design. WITS can also produce a crosswalk from the State codes to the standard TEDS codes.

So far, Alaska, Illinois, Iowa, Nevada, and Salt Lake County are deploying WITS.

Closing Remarks

Charlene thanked all the participants for their input during the meeting and expressed her appreciation for the work State participants did in developing and making their presentations. Once again the interaction was most useful to OAS and DASIS staff.

DASIS REGIONAL MEETING

Alaska, Arizona, Colorado, Kansas, New Mexico, Oklahoma, Utah, Texas
October 26–27
Dallas, TX

Thursday

8:15 a.m. **Continental Breakfast**

8:45 a.m. **Welcome and Introductions** ..... ***Charlene Lewis, OAS***

9:00 a.m. **National Survey of Substance Abuse Treatment Services (N-SSATS)** ..... ***Geri Mooney, MPR***
- **2004 survey response rates** ..... ***Barbara Rogers, MPR***
- **Internet access and responding by mode**
- **Accuracy of reporting by mode**
- **Measuring outpatient capacity**
- **Getting State input on real-world issues that affect the N-SSATS**

10:00 a.m. **Inventory of Substance Abuse Treatment Services (I-SATS)** ..... ***Alicia McCoy, Synectics***
- **Importance of I-SATS updates** ..... ***Jim DeLozier, Synectics***
- **Approved vs. non-approved facilities and process for review** ..... ***Deborah Trunzo, OAS***
- **National Provider Identifier**

10:30 a.m. **BREAK**

10:45 a.m. **SAMHSA Initiatives and Potential Impact on DASIS** ..... ***Charlene Lewis, OAS***

11:15 a.m. **Treatment Episode Data Set (TEDS)** ..... ***Leigh Henderson, Synectics***
- **The status of TEDS—Admissions and Discharge Data Sets** ..... ***Jim DeLozier, Synectics***
- **Monitoring discharge submissions**
- **Latest findings from TEDS**

12:30 p.m. **LUNCH**

1:15 p.m. **State Presentations** ..... ***State participants—AK, AZ, CO, KS***

2:45 p.m. **BREAK**

3:00 p.m. **State Presentations—continued** ..... ***State participants—NM, OK, TX, UT***

4:30 p.m. **Adjourn**

Friday

8:15 a.m. Continental Breakfast

8:45 a.m. Plans for Sub-state Estimates from the NSDUH ..... ***Doug Wright, OAS***

9:45 a.m. BREAK

10:00 a.m. WITS ..... ***Javaid Kaiser, CSAT***
..... ***Maureen Kelly, Westat***

11:00 a.m. Wrap-up

11:30 a.m. Adjourn

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Dallas, Texas
October 26–27, 2004

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